		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004721

Facility Name: GENESEO GOOD SAMARITAN VILLAGE

Address: 704 S ILLINOIS ST (Number) GENESEO (City) 61254 (Zip Code)

County: HENRY

Telephone Number: (309)944-6424 **Fax #** (309)944-6605

IDPA ID Number: 45-0228055

Date of Initial License for Current Owners: 1/1/1970

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501(c)(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: ALETA CARLSON **Telephone Number:** (605)362-3100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,352	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,352	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,330	16,352	1,076	25,758	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,330	16,352	1,076	25,758	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.75%

D. How many bed-hold days during this year were paid by Public Aid?
26 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1/1/1971

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 1,076

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	173,186	18,950	7,857	199,993		199,993		199,993			1
2	Food Purchase		131,142		131,142		131,142	(4,457)	126,685			2
3	Housekeeping	80,839	13,865		94,704		94,704	(8)	94,696			3
4	Laundry	61,555	15,341		76,896		76,896		76,896			4
5	Heat and Other Utilities			55,346	55,346		55,346	(380)	54,966			5
6	Maintenance	72,043	15,122	68,485	155,650		155,650	233	155,883			6
7	Other (specify):*			2,982	2,982		2,982		2,982			7
8	**TOTAL General Services**	387,623	194,420	134,670	716,713		716,713	(4,612)	712,101			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	871,680	75,266	12,868	959,814	(19,085)	940,729	(22,445)	918,284			10
10a	Therapy	68,619	1,003	99,506	169,128		169,128	(73,371)	95,757			10a
11	Activities	53,066	8,387	4,463	65,916		65,916	(375)	65,541			11
12	Social Services	30,244	49	1,004	31,297		31,297		31,297			12
13	Nurse Aide Training					19,085	19,085		19,085			13
14	Program Transportation			3,848	3,848		3,848		3,848			14
15	Other (specify):*	26,937			26,937		26,937		26,937			15
16	**TOTAL Health Care and Programs**	1,050,546	84,705	121,689	1,256,940		1,256,940	(96,191)	1,160,749			16
	C. General Administration											
17	Administrative	40,360		113,029	153,389		153,389	5,791	159,180			17
18	Directors Fees											18
19	Professional Services			6,865	6,865		6,865		6,865			19
20	Dues, Fees, Subscriptions & Promotions			26,156	26,156		26,156	(15,889)	10,267			20
21	Clerical & General Office Expenses	47,592	13,091	33,108	93,791		93,791	(5,624)	88,167			21
22	Employee Benefits & Payroll Taxes			256,471	256,471		256,471	24,983	281,454			22
23	Inservice Training & Education			24,854	24,854		24,854	(611)	24,243			23
24	Travel and Seminar			3,481	3,481		3,481	(120)	3,361			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			12,051	12,051		12,051	(407)	11,644			26
27	Other (specify):*	18,896		1,257	20,153		20,153	(18,896)	1,257			27
28	**TOTAL General Administration**	106,848	13,091	477,272	597,211		597,211	(10,773)	586,438			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,545,017	292,216	733,631	2,570,864		2,570,864	(111,576)	2,459,288			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE #0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			179,088	179,088		179,088	(12,404)	166,684			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,187	6,187		6,187	(6,187)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			520	520		520	(520)				34
35	Rent-Equipment & Vehicles			3,283	3,283		3,283		3,283			35
36	Other (specify):*											36
37	**TOTAL Ownership**			189,078	189,078		189,078	(19,111)	169,967			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,973	1,973		1,973		1,973			39
40	Barber and Beauty Shops			(606)	(606)		(606)	606				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,420	39,420		39,420		39,420			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			40,787	40,787		40,787	606	41,393			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,545,017	292,216	963,496	2,800,729		2,800,729	(130,081)	2,670,648			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,457)	2		4
5	Telephone, TV & Radio in Resident Rooms	(380)	5		5
6	Rented Facility Space	(520)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,187)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(75)	6		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,935)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Sch	(140,112)	varies		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (162,666)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	32,585	sch att	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 32,585		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (130,081)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GENESEO GOOD SAMARITAN VILLAGE

ID# 0004721

Report Period Beginning: 1/1/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Uniform Inc	$ (3,249)	21	1
2	Hskp/Maid Svc	(8)	3	2
3	Postage Inc	(34)	21	3
4	Activity Inc	(375)	11	4
5	Home Sale Program Rent	(1,547)	30	5
6	Depreciation Exp - Apt/Duplex	(10,857)	30	6
7	Public Rel - Reimb	(4,497)	20	7
8	Presc Drugs - Reimb	(18,955)	10	8
9	Barber/Beauty Exp	606	40	9
10	Res Dev - Salaries, Vac Acc	(10,463)	27	10
11	Res Dev - FICA	(2,218)	22	11
12	Res Dev - Supplies, Sm Equip, Misc Fdraiser	(2,341)	21	12
13	Res Dev - Travel	(120)	24	13
14	Res Dev - Staff Dev	(611)	23	14
15	Therapy Offset - PT, OT, ST	(73,371)	10a	15
16	Marketing - Salaries	(8,433)	27	16
17	Supplies -Part B	(2,638)	10	17
18	Glucose Strip Exp	(852)	10	18
19	Deferred Maint Exp - 2000	(3,714)	6	19
20	Deferred Maint Exp - 1996 -1999	4,022	6	20
21	Dues - Non Reimb	(457)	20	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(140,112)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,457)	0	0	0	0	0	0	0	0	0	0	(4,457)	2
3	Housekeeping	(8)	0	0	0	0	0	0	0	0	0	0	(8)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(380)	0	0	0	0	0	0	0	0	0	0	(380)	5
6	Maintenance	233	0	0	0	0	0	0	0	0	0	0	233	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,612)	0	0	0	0	0	0	0	0	0	0	(4,612)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(22,445)	0	0	0	0	0	0	0	0	0	0	(22,445)	10
10a	Therapy	(73,371)	0	0	0	0	0	0	0	0	0	0	(73,371)	10a
11	Activities	(375)	0	0	0	0	0	0	0	0	0	0	(375)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(96,191)	0	0	0	0	0	0	0	0	0	0	(96,191)	16
	C. General Administration													
17	Administrative	0	5,791	0	0	0	0	0	0	0	0	0	5,791	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(15,889)	0	0	0	0	0	0	0	0	0	0	(15,889)	20
21	Clerical & General Office Expenses	(5,624)	0	0	0	0	0	0	0	0	0	0	(5,624)	21
22	Employee Benefits & Payroll Taxes	(2,218)	27,201	0	0	0	0	0	0	0	0	0	24,983	22
23	Inservice Training & Education	(611)	0	0	0	0	0	0	0	0	0	0	(611)	23
24	Travel and Seminar	(120)	0	0	0	0	0	0	0	0	0	0	(120)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(407)	0	0	0	0	0	0	0	0	0	(407)	26
27	Other (specify):*	(18,896)	0	0	0	0	0	0	0	0	0	0	(18,896)	27
28	**TOTAL General Administration**	(43,358)	32,585	0	0	0	0	0	0	0	0	0	(10,773)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(144,161)	32,585	0	0	0	0	0	0	0	0	0	(111,576)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 **Report Period Beginning:** 1/1/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(12,404)	0	0	0	0	0	0	0	0	0	0	(12,404)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,187)	0	0	0	0	0	0	0	0	0	0	(6,187)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(520)	0	0	0	0	0	0	0	0	0	0	(520)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(19,111)	0	0	0	0	0	0	0	0	0	0	(19,111)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	606	0	0	0	0	0	0	0	0	0	0	606	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	606	0	0	0	0	0	0	0	0	0	0	606	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(162,666)	32,585	0	0	0	0	0	0	0	0	0	(130,081)	45

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Ev. Lutheran Good Samaritan Society	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Admin/Acctg	$ 113,029	The Ev Lutheran Good Samaritan Society	100.00%	$ 118,820	$ 5,791	1
2	V									2
3	V		22	Unemployment						3
4	V									4
5	V		22	Workers Comp	1,003			28,204	27,201	5
6	V									6
7	V		26	Prop&Liab Ins	12,050			11,643	(407)	7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 126,082			$ 158,667	$ * 32,585	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAG # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5	NOT APPLICABLE										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: The Ev Lutheran Good Samaritan Society
Street Address: 4800 W 57th St PO Box 5038
City / State / Zip Code: Sioux Falls, SD 57117-5038
Phone Number: ((605)362-3100
Fax Number: ((605)362-3265

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See under separate cover the				$	$		$	1
2		'Report on Allowable Central								2
3		Office Expenses for the Year								3
4		ended December 31, 2000'								4
5										5
6										6
7		*The allocated expenses in this report related directly to each centers								7
8		nursing home facility and no additional re-allocation of these expenses								8
9		between healthcare facilities and non healthcare facilities/apartments								9
10		should be necessary								10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	AETNA		x	Bldg & Equip	(1)	5/20/1987	$ 275,941	$ 68,276	11/1/2001	0.0897	$ 6,090	1
2	Bank of America					12/1999	248,709	1,365				2
3												3
4												4
5												5
	Working Capital											
6	Central Office Advance										97	6
7												7
8												8
9	TOTAL Facility Related						$ 524,650	$ 69,641			$ 6,187	9
	B. Non-Facility Related*											
10												10
11	(1) Interest paid qtrly at 2/1, 5/1, 8/1, and 11/1											11
12	Principal paid annually at 11/1											12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 524,650	$ 69,641			$ 6,187	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE **#** 0004721 **Report Period Beginning:** 1/1/2000 **Ending:** 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	2,338	8
1996	5,158	9
1997	7,296	10
1998	4,066	11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,848 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APARTMENTS - 8 UNITS
DUPLEXES - 12 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1969	$ 26,000	1
2					2
3	TOTALS			$ 26,000	3

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		1971	1971	$ 494,739	$ 12,369		$ 12,369	$	$ 367,963	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building			1977	1,100	-	varies	-		1,100	9
10				1978	7,629	-	20	-		7,629	10
11				1981	169,320	5,451	varies	5,451		112,079	11
12				1982	2,299	65	varies	65		2,207	12
13				1986	3,335	15	varies	15		3,259	13
14				1987	15,313	520	varies	520		11,930	14
15				1988	132,771	5,313	varies	5,313		92,298	15
16				1989	26,987	724	varies	724		23,467	16
17				1990	148,304	5,764	varies	5,764		96,411	17
18				1991	5,106	128	varies	128		4,763	18
19				1992	99,897	2,573	varies	2,573		86,311	19
20				1993	80,357	4,864	varies	4,864		39,853	20
21				1994	73,192	4,491	varies	4,491		35,417	21
22				1995	76,365	4,715	varies	4,715		26,493	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,336,714	$ 46,992		$ 46,992	$	$ 911,180	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building continued --										9
10	Ceramic Flooring			1996	107	5	20	5		27	10
11	Laundry Wall Protection			1996	1,109	222	5	222		1,109	11
12	Activity Room Remodel/Sink			1996	2,132	427	5	427		2,132	12
13	Laundry Doors			1996	1,874	125	15	125		604	13
14	Bathroom Sink			1996	678	34	20	34		167	14
15	Awning for Rehab Clinic			1996	983	98	10	98		467	15
16											16
17	Kemlite in Closets			1996	653	65	10	65		305	17
18	Power Access Door Operator			1996	1,009	101	10	101		471	18
19	Generator/Move to GSS			1996	3,431	343	10	343		1,601	19
20	Carpet for Parlor			1996	2,627	525	5	525		2,408	20
21	A/C-Roof Top on 200 Wing			1996	229	15	15	15		69	21
22	Electric-Remodel Parlor			1996	186	9	20	9		42	22
23	Building-Remodel Parlor			1996	1,132	57	20	57		255	23
24	Plumbing-Remodel Parlor			1996	599	30	20	30		135	24
25	Carpet-Remodel Parlor			1996	1,164	233	5	233		1,067	25
26	Wallpaper-Remodel Parlor			1996	2,645	529	5	529		2,425	26
27	Shower Remodel-Grab Bars			1996	1,321	132	10	132		562	27
28	Carpet for Resident Room			1996	768	154	5	154		627	28
29	Replace Fixtures/Floor/Wall			1996	3,955	198	20	198		824	29
30	Windows			1996	25,212	1,681	15	1,681		7,003	30
31	Building-Remodel			1996	1,692	85	20	85		374	31
32	Wallpaper for Resident Room			1997	2,976	595	5	595		2,331	32
33	Window for Dining Room			1997	1,650	110	15	110		431	33
34	300 Wing Ceiling Tile Work			1997	2,584	517	5	517		2,024	34
35				1997	1,013	101	10	101		397	35
36	TOTAL (lines 4 thru 35)				$ 61,729	$ 6,391		$ 6,391	$	$ 27,857	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	**Building continued--**										9
10	Wallpaper in residents room			1997	3,838	768	6	768		3,006	10
11	Windows			1997	5,100	340	15	340		1,332	11
12	Carpet & Padding			1997	1,401	280	6	280		1,097	12
13	Wallpaper for Jack Andrews			1997	2,221	444	5	444		1,740	13
14	Carpet for Conference Room			1997	2,192	438	5	438		1,680	14
15	Conference Work Room			1997	1,350	135	10	135		529	15
16	Wall Protection			1997	739	148	5	148		567	16
17	New Sprinklers for Office			1997	909	91	10	91		333	17
18	Carpet			1997	768	154	6	154		550	18
19	Wallpaper-Resident Room #308			1997	2,667	533	5	533		1,911	19
20	Floorcovering and Labor			1997	975	195	5	195		699	20
21	Wallpaper for Offices			1997	782	156	5	156		560	21
22	Carpet for Resident Room			1997	506	101	5	101		363	22
23	Environmental Assessment of 61			1997	1,739	174	10	174		609	23
24	Roof-Front Entry			1997	21,178	1,059	20	1,059		4,147	24
25	Social Service & Conference Room			1997	1,392	93	15	93		325	25
26	D.O.N. & Staff Development Office			1997	1,236	82	15	82		288	26
27	Wallpaper-Room 308			1997	1,440	288	5	288		1,008	27
28	Drain/Sewer Work			1997	389	26	15	26		89	28
29											29
30	Floor Covering-Offices & Resid			1997	564	113	6	113		376	30
31	Ceiling Tiles			1997	1,390	278	6	278		880	31
32	Remodel Work in Room 309			1997	1,464	98	15	98		309	32
33	Siderail 1/2 Deluxe			1997	958	64	15	64		202	33
34	Siderails			1997	556	37	15	37		114	34
35	Drywall-Nurse Station			1997	625	125	5	125		385	35
36	**TOTAL (lines 4 thru 35)**				**$ 56,379**	**$ 6,220**		**$ 6,220**	**$**	**$ 23,099**	36

***Total beds on this schedule must agree with page 2.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building continued --										9
10	Rehab Wall Work			1997	414	83	5	83		255	10
11	Carpet			1997	1,396	279	5	279		861	11
12											12
13	Reroofing			1997	64,129	3,206	20	3,206		10,154	13
14	Building-Remodel Nurses Station			1998	18,510	740	25	740		2,221	14
15	Carpet-Remodel Nurses Station			1998	1,753	351	5	351		1,052	15
16	Wallcovering-Remodel Nurses Station			1998	1,794	359	5	359		1,077	16
17	Form & Pour Lamp Post Bases			1998	780	160	5	160		480	17
18	Floor Covering			1998	735	147	5	147		441	18
19											19
20	Side Rails			1998	812	54	15	54		162	20
21	Kitchen Door			1998	1,242	83	15	83		228	21
22	Cabinetry & Installation			1998	3,799	190	20	190		522	22
23	Room 204 Work			1998	2,532	253	10	253		696	23
24	Vinyl Covering-Kick Plates			1998	1,367	137	10	137		376	24
25	Handrail & Installation			1998	700	47	15	47		128	25
26	Fire Alarm System Workr			1998	1,090	109	10	109		291	26
27	Bathroom Fixtures			1998	412	41	10	41		106	27
28	Roof Flashing Installation			1998	753	75	10	75		195	28
29	Koroguard in Med Room and Bath			1998	1,008	101	10	101		260	29
30	Carpet			1998	555	111	5	111		287	30
31	Generator			1998	47,534	2,377	20	2,377		6,536	31
32	Boiler Tank			1998	3,803	380	10	380		951	32
33	Door Frame Guards			1998	593	40	15	40		99	33
34	Water Heater & Labor			1998	1,339	134	10	134		324	34
35	Floor Covering Ceiling Tile			1998	1,398	280	5	280		652	35
36	**TOTAL (lines 4 thru 35)**				**$ 158,448**	**$ 9,737**		**$ 9,737**	**$**	**$ 28,354**	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building continued --										9
10	Resident Room Work			1998	996	199	5	199		548	10
11	Ceiling Tile			1998	20,525	1,026	20	1,026		2,395	11
12	Project			1998	6,817	341	20	341		767	12
13	Bathroom Work			1998	2,121	212	10	212		477	13
14	Aluminum Entrance/Ambulance			1999	1,726	115	15	115		221	14
15	Air Conditioning			1998	24,279	1,559	15	1,559		3,304	15
16	HVAC Systems			1998	4,285	275	15	275		583	16
17	Roof Work			1999	2,800	280	10	280		443	17
18											18
19	Wood Sign			1999	327	33	10	33		46	19
20	HVAC			1999	2,350	235	10	235		372	20
21	Plumbing-Bathroom Remodel			1999	4,739	237	20	237		395	21
22	Building-Remodel Resident Room			1999	6,295	252	25	252		294	22
23	Drapes-Remodel Resident Room			1999	279	56	5	56		65	23
24	Electric-Remodel Resident Room			1999	197	10	20	10		11	24
25	Paint-Remodel Resident Room			1999	2,697	539	5	539		629	25
26											26
27	Faucets			2000	1,159	34	20	34		34	27
28	Oak Cabinets for Kitchen			2000	1,603	80	15	80		80	28
29	Laundry Repair			2000	533	80	5	80		80	29
30	Building-Rental Prop Improvement			2000	19,696	460	25	460		460	30
31	Carpet-Rental Prop Improvement			2000	60	7	5	7		7	31
32	Generator Repair			2000	2,258	38	10	38		28	32
33	Water Softener			2000	541	5	10	5		5	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 106,283	$ 6,073		$ 6,073	$	$ 11,244	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvement										9
10				1971-1975	22,290	-	15	-		22,290	10
11				1978	4,541	-	15	-		4,541	11
12				1981	5,292	192	15	192		5,292	12
13				1985	6,089	169	15	169		6,089	13
14				1988	62,030	4,135	15	4,135		49,968	14
15				1990	3,857	121	10	121		3,857	15
16				1991	11,223	561	20	561		5,190	16
17				1992	16,042	1,160	varies	1,160		13,692	17
18				1995	15,860	1,057	varies	1,057		5,551	18
19	Bury Electric Line			1996	3,347	335	10	335		1,646	19
20											20
21	Gazebo			1997	2,850	143	20	143		523	21
22	Walk			1997	2,500	167	15	167		611	22
23	Entrance Area Landscaping			1997	2,450	245	10	245		837	23
24	Sprinkler System			1997	727	48	15	48		149	24
25	Parking Lot			1997	2,266	113	20	113		368	25
26	Courthouse Research For Prepari			1998	515	52	10	52		150	26
27	Patio			1998	1,314	131	10	131		318	27
28	Skylight & Flashing Work			1998	1,607	161	10	161		388	28
29	Sidewalk			1999	475	48	10	48		75	29
30	0101 - 50% Nrsg --										30
31	Seal Coat Parking Lot			1987	790	-	12	-		790	31
32	Parking Lot Expansion			1999	13,797	690	20	690		805	32
33											33
34	Total Land Improvements				179,862	9,528		9,528		123,130	34
35											35
36	TOTAL (lines 4 thru 35) Pages 12 - 12E				$ 1,899,415	$ 84,941		$ 84,941	$	$ 1,124,864	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 575,388	$ 56,270	$ 56,270	$		$ 307,108	37
38	Current Year Purchases	29,513	2,082	2,082			2,082	38
39	Fully Depreciated Assets	220,768	4,590	4,590			220,768	39
40								40
41	TOTALS	$ 825,669	$ 62,942	$ 62,942	$		$ 529,958	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Truck		1994	$ 3,000	$	$	$	2	$ 3,000	42
43	Rebuilding Truck		1996	3,596	674	674		4	3,596	43
44	19 passenger van	1998 Ford Eld	1998	46,636	7,773	7,773		6	21,375	44
45										45
46	TOTALS			$ 53,232	$ 8,447	$ 8,447	$		$ 27,971	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,624,454	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 156,330	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 156,330	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,559,663	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Apt's & Duplex	$	$	$	52
53	Land	134,693			53
54	Land Imp	39,246	1,807	22,254	54
55	Bldg	2,159,157	53,279	325,973	55
56	FFE	81,877	4,413	46,175	56
57	TOTALS	$ 2,414,973	$ 59,499	$ 394,402	57

G. Construction-in-Progress

	Description	Cost	
58	CIP	$ 86,173	58
59			59
60			60
61		$ 86,173	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 3,283 Description: network computer equip lease, one time rentals
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 90

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$ 484	$	$	$ 484
2	Books and Supplies		37			37
3	Classroom Wages	(a)	1,188	7,722		8,910
4	Clinical Wages	(b)		4,118		4,118
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments		160	4,700		4,860
8	Nurse Aide Competency Tests			676		676
9	TOTALS		$ 1,869	$ 17,216	$	$ 19,085
10	SUM OF line 9, col. 1 and 2	(e)	$ 19,085			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	17

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs	NOT APPLICABLE					#VALUE!	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 **Report Period Beginning:** 1/1/2000 **Ending:** 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 89,069	$	1
2	Cash-Patient Deposits	5,672		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance #12991-4)	416,285		3
4	Supply Inventory (priced at COST)	7,711		4
5	Short-Term Investments	1,677,169		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	768		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Empl Advance	(21)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,196,653	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	160,693		13
14	Buildings, at Historical Cost	4,026,042		14
15	Leasehold Improvements, at Historical Cost	270,017		15
16	Equipment, at Historical Cost	961,967		16
17	Accumulated Depreciation (book methods)	(2,116,407)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	19,179		21
22	Other Long-Term Assets (spe Asset mgmt Purch	1,328		22
23	Other(specify): CIP	86,173		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,408,992	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,605,645	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 40,273	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	206,262		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,875		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,126		32
33	Accrued Interest Payable	1,267		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Apt Security Dep&Entry Fees	19,233		36
37	Misc W/holdings/Group Ins	(2,548)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 433,488	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	68,276		40
41	Bonds Payable	1,365		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Refund/NonRefund Duplex Entry Fees	1,004,919		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,074,560	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,508,048	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,097,597	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,605,645	$	48

***(See instructions.)**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,850,380	1
2	Restatements (describe):		2
3	**Unit 40 Apts**	12,006	3
4	**Unit 41 Apts**	99,383	4
5	**Unit 45 - Duplexes**	59,075	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,020,844	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	89,202	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Donor Rest Prop/Oper Gift - Cash**	(15,833)	15
16	Other (describe) **Intra-co N/A- CO**	3,375	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 76,744	17
	B. Transfers (Itemize):		
18			18
19	**Rounding**	9	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 9	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,097,597	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,885,044	1
2	Discounts and Allowances for all Levels	(374,806)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,510,238	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	6,036	5
6	Therapy	251,484	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 257,520	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	708	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,456	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,448	16
17	Sale of Drugs	39,976	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,930	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 56,518	23
	D. Non-Operating Revenue		
24	Contributions	8,321	24
25	Interest and Other Investment Income***	29,508	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37,829	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical & Nursing Supplies	21,177	28
28a	Schedule Attached	6,649	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,826	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,889,931	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	716,713	31
32	Health Care	1,256,940	32
33	General Administration	597,211	33
	B. Capital Expense		
34	Ownership	189,078	34
	C. Ancillary Expense		
35	Special Cost Centers	1,367	35
36	Provider Participation Fee	39,420	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,800,729	40
41	**Income before Income Taxes (line 30 minus line 40)****	89,202	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 89,202	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,862	2,090	$ 45,483	$ 21.76	1
2	Assistant Director of Nursing	912	945	15,386	16.28	2
3	Registered Nurses	8,349	9,037	132,574	14.67	3
4	Licensed Practical Nurses	7,262	7,567	90,952	12.02	4
5	Nurse Aides & Orderlies	52,058	57,156	521,987	9.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,141	5,695	69,025	12.12	8
9	Activity Director	1,961	2,204	24,716	11.21	9
10	Activity Assistants	3,656	3,925	28,324	7.22	10
11	Social Service Workers	2,031	2,213	30,223	13.66	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,135	26,106	12.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,572	17,639	146,390	8.30	15
16	Dishwashers					16
17	Maintenance Workers	5,607	6,034	70,550	11.69	17
18	Housekeepers	9,131	9,998	81,477	8.15	18
19	Laundry	6,593	7,323	62,429	8.53	19
20	Administrator	1,717	1,891	40,551	21.44	20
21	Assistant Administrator					21
22	Other Administrative	156	159	2,099	13.20	22
23	Office Manager	1,991	2,120	23,913	11.28	23
24	Clerical	1,837	1,958	21,850	11.16	24
25	Vocational Instruction					25
26	Academic Instruction	1,814	2,054	27,065	13.18	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,767	2,946	32,381	10.99	31
32	Other Health C: Nrsg Secretary	2,081	2,313	28,427	12.29	32
33	Other(specify) Mktg&Res Dev	1,244	1,331	18,285	13.74	33
34	TOTAL (lines 1 - 33)	136,798	148,733	$ 1,540,193 *	$ 10.36	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	152	$ 6,817	line 1, col 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	5	287	line 11, col 3	44
45	Social Service Consultant	19	1,004	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	175	$ 8,108		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mike Olson	Administrator		$ 40,551
vacation accrual			(191)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 40,360

B. Administrative - Other

Description	Amount
Admin/Acctg	$ 113,029
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 113,029

C. Professional Services

Vendor/Payee	Type	Amount
BDO Seidman	Mdcre Cost Report Prep	$ 3,300
Good Sam Society	Mdcd Cost Report Prep	200
Berens & Tate	Prof Svc & Exp	44
Survey Fee	Joint Commission	1,842
Texas Medical Foundation	Credentialing	830
Nash, Nash, Bean	City code matters	135
Contract serv		514
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 6,865

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,204
Unemployment Compensation Insurance	
FICA Taxes	117,107
Employee Health Insurance	104,392
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
Work Comp Ins - Pd Direct	(714)
Taxable Gifts Payment	4,914
Staff Pension	28,009
Employee Physicals	72
Admin/Consultant Svgs	1,688
Less:Res Dev - FICA	(2,218)
TOTAL (agree to Schedule V, line 22, col.8)	$ 281,454

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,935
Health Care Worker Background Check	
(Indicate # of checks performed)	
Publications - Admin	673
Public Relations	4,497
Dues - Reimb	9,973
Publications - Reimb - Nrsg	78
Less:Dues-NonReimb	(457)
Less: Public Relations Expense	(4,497)
Non-allowable advertising	(10,935)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,267

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,318
Seminar Expense	2,163
Less: Res Dev Travel	(120)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,361

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting	6/96	$ 2,178	5	$ 436	$ 436	$ 436	$ 436	$ 217	$	$	$	$
2	Wallpaper	12/96	1,679	5	336	336	336	336	335				
3	Painting	11/96	843	5	169	169	169	169	153				
4	Wallpaper/Paint	12/96	1,524	5	305	305	305	305	304				
5	Wallpaper/Paint	10/96	181	5	36	36	36	36	31				
6	Painting	8/96	425	5	85	85	85	85	57				
7	Painting	7/96	33	5	7	7	7	7	2				
8	Painting	6/96	239	5	48	48	48	48	23				
9	Painting	5/96	117	5	23	23	23	23	11				
10	Painting	4/96	38	5	8	8	8	8	1				
11	Painting	3/96	123	5	25	25	25	25	5				
12	Painting	2/96	22	5	4	4	4	4	3				
13	Painting PT Room	12/95	1,791	5	358	358	358	359	0				
14	Paint & Labor	1/97	1,539	5	282	308	308	308	308	25			
15	Paint	3/97	23	5	3	4	4	4	4	4			
16	Paint	4/97	37	5	5	7	7	7	7	4			
17	Paint	5/97	45	5	5	9	9	9	9	4			
18													
19													
20	TOTALS		$ 10,837		$ 2,135	$ 2,168	$ 2,168	$ 2,169	$ 1,470	$ 37	$	$	$

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE **#** 0004721 **Report Period Beginning:** 1/1/2000 **Ending:** 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **0**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10 yr**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,332** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **39,420**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **yes** Indicate the amount. $ **4,457**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **.33**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Henry Scholten & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting	1/98	$ 283	5	$	$ 57	$ 57	$ 57	$ 57	$ 55	$ 0	$	$
2	Painting	3/98	362	5		54	72	72	72	72	20		
3	Painting	4/98	343	5		45	69	69	69	69	22		
4	Painting	5/98	723	5		83	145	145	145	145	60		
5	Painting	6/98	38	5		4	8	8	8	8	2		
6	Painting	7/98	65	5		7	13	13	13	13	6		
7	Painting	8/98	361	5		30	72	72	72	72	43		
8	Painting	10/98	75	5		4	15	15	15	15	11		
9	Painting	12/98	864	5		14	173	173	173	173	158		
10	Painting	2/99	1,800	5			300	360	360	360	360	60	
11	Painting	3/99	4,032	5			605	806	806	806	806	203	
12	Painting	4/99	97	5			13	19	19	19	19	8	
13	Painting	7/99	44	5			4	9	9	9	9	4	
14	Painting	8/99	10	5			1	2	2	2	2	1	
15	Painting	9/99	130	5			6	26	26	26	26	20	
16	Painting	11/99	34	5			1	7	7	7	7	5	
17													
18													
19													
20	TOTALS		$ 9,261		$	$ 298	$ 1,554	$ 1,853	$ 1,853	$ 1,851	$ 1,551	$ 301	$

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Wallpaper	7/00	$ 1,295	5	$	$	$	$ 129	$ 259	$ 259	$ 259	$ 259	$ 130
2	Wallpaper/Paint	12/00	2,533	5				42	506	507	507	507	464
3	Paint	6/00	64	5				7	13	13	13	12	6
4													
5													
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10													
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19													
20	TOTALS		$ 3,892		$	$	$	$ 178	$ 778	$ 779	$ 779	$ 778	$ 600